Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $2,143.00 for date of service 10/03/01.

   b. The request was received on 01/22/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 01/10/02
   b. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. There is not a carrier signed sheet nor a 14 day response in the dispute packet. Therefore, Medical Review will review all information in the case file.

III. PARTIES' POSITIONS

1. Requestor:

   "We received approval from WICF (800-859-5995) to treat patient and sent a complete two-page treatment plan on August 14, 2001 totaling $4688.00. The treatment plan included treating the acute fractured teeth with exposed nerve endings and dentin, as well as the final restoration of these cracked teeth: porcelain jacket crowns. This treatment plan was received at the (Carrier) on August 17, 2001 10:50 AM as indicated by your stamp… To date we have received partial payment for a portion of this treatment, $1274.46 on 10/01/01 and $1046.06 on 10/04/01. The remaining balance is $2371.47."

2. Respondent:

The respondent did not submit a letter of response to Dispute Resolution.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 10/03/01.

2. A-PREAUTHORIZATION REQUIRED BUT NOT REQUESTED."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
10/03/01	D2740	$2,085.00	$0.00	A		TWCC Rule 134.600(h)(16)	According to the referenced rule, preauthorization must be obtained for "all non-emergency dental services, including reconstructive dental care or dental appliances." The date of service in dispute is one month post injury and requires preauthorization. The provider did not submit any documentation that preauthorization was obtained. Therefore, reimbursement is not recommended.
10/03/01	D1110	$58.00	$0.00	A		TWCC Rule 134.600(h)(16)	According to the referenced rule, preauthorization must be obtained for "all non-emergency dental services, including reconstructive dental care or dental appliances." The provider did not submit any documentation that preauthorization was obtained. Therefore, reimbursement is not recommended.
Totals		$2,143.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 20th day of June 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.